WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

3507

1. PLACE OF DEATH FEB 5 1935

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. Christian Hospital St. ..... Ward)

File No. ..... Registered No. 814

2. FULL NAME Lillian Gable

(a) Residence, No. 3606 Palm St., 10 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF: Arthur W. Gable

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Feb. 20-1889

7. AGE: YEARS 45 | MONTHS 11 | DAYS 1 | If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: at Home
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Chicago Ill.

FATHER
13. NAME: Charles Sloncen
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Chicago Ill.

MOTHER
15. MAIDEN NAME: Amelia Nenneman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

17. INFORMANT (ADDRESS): Arthur W. Gable 3606 Palm St.

18. ~~BURIAL, CREMATION, OR~~ REMOVAL
PLACE Chicago Ill. DATE Jan. 23, 1935

19. UNDERTAKER (ADDRESS): Cullinane Bros. 1710 N. Grand Bl.

20. FILED JAN 22 1935 19 J. F. Bredick Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Jan 21, 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1935, to Jan 21, 1935
I last saw her alive on Jan 21, 1935. Death is said to have occurred on the date stated above, at 8:40 p.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| General Peritonitis | 1/19 |
| Pelvic abscess | 1/18 |
| 1390 | |

Other contributory causes of importance:

| | |
|---|---|
| Pelvic Cellulitis | 1/17 |

Name of operation Laparotomy Date of 1/21/35
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) R. M. Elvan, M. D.
(Address) 4356 Warne av

100M-11-24-33

[illegible] Clark X356 Wainwright

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

File No. 814

Registered No. ~~[illegible]~~

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Lillian Gable

(a) Residence, No. ..... St., ..... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

17. INFORMANT ..... (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19....

19. UNDERTAKER ..... (ADDRESS)

20. FILED 1-22 1935 Jos. F. Bredeck Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-21 1935

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Abscess & cellulitis, non-puerperal, non-tubercular, non-rheumatic. Cause unknown.

Date of onset

Other contributory causes of importance:

1398

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ..... , M. D.

(Address) .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. .....

Township ..... Primary Registration District No. .....

File No. ..... 6603

Registered No. .....

City ..... (No. ....., ..... St. ..... Ward

2. FULL NAME .....

(a) Residence, No. ..... St., ..... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) |
|---|---|---|
| | | |

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min. |
|---|---|---|---|---|
| | | | | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ..... S 3507

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

17. INFORMANT .....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ....., 19....

19. UNDERTAKER .....
(ADDRESS)

20. FILED ....., 19.... .....
*Registrar.*

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) ....., 19

22. I HEREBY CERTIFY, That I attended deceased fr
....., 19....., to ....., 19
I last saw h..... alive on ....., 19..... Death is s
to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follov

| | Date of on |
|---|---|
| | |
| | |
| | |
| | |
| | |

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) ....., M. I

(Address) .....